Senate Bill No. 920

CHAPTER 452

An act to amend Sections 14169.3, 14169.5, 14169.7, 14169.7.5, 14169.11, 14169.16, 14169.17, 14169.18, 14169.31, 14169.32, 14169.33, 14169.41, and 14169.42 of, and to add Section 14166.125 to, the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 22, 2012. Filed with Secretary of State September 22, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

SB 920, Hernandez. Medi-Cal: hospitals.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing law establishes the continuously appropriated Private Hospital Supplemental Fund, administered by the California Medical Assistance Commission, which consists of moneys from various sources used to fund the nonfederal share of supplemental payments to private hospitals. Existing law requires that the California Medical Assistance Commission be dissolved after June 30, 2012, and requires that, upon dissolution of the commission, all powers, duties, and responsibilities of the commission be transferred to the Director of Health Care Services.

This bill, effective the first fiscal year in which reimbursement is provided to private hospitals under a specified methodology, would require the Director of Health Care Services to allocate the fund among eligible private hospitals pursuant to a methodology that is developed in consultation with the statewide associations representing children's hospitals and private DSH hospitals and that ensures, to the extent possible, the hospitals are allocated funding at the level of payments received for the 2011–12 fiscal year, taking into consideration applicable eligibility criteria.

Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals for the period of July 1, 2011, through December 31, 2013. Existing law requires the hospitals to pay the fee in 10 equal installments, as specified, and requires that the moneys collected from the quality assurance fee be deposited into the Hospital Quality Assurance Revenue Fund. Existing law, subject to federal approval, requires that the moneys in the fund be available, upon appropriation by the Legislature, only for certain purposes, including, among other things, making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans,

and increased payments to mental health plans. Existing law also authorizes designated and nondesignated public hospitals to be paid direct grants in support of health care expenditures funded by the quality assurance fee.

Existing law, subject to federal approval of a Medicaid demonstration project, requires the department to authorize local Low Income Health Programs (LIHPs), as defined, to provide scheduled health care services to eligible individuals, which includes the Medicaid Coverage Expansion (MCE) population, as defined. Existing law establishes the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund, which consists of moneys transferred from governmental entities on a voluntary basis and from the Hospital Quality Assurance Revenue Fund in specified amounts, to be used by the department, upon appropriation by the Legislature, to fund the nonfederal share of supplemental payments made to private hospitals and nondesignated public hospitals that are outside the LIHP coverage network for providing emergency and poststabilization services to the MCE population.

Existing law provides that the provisions governing the various payments and grants shall become inoperative on September 1, 2013, if the department has not received federal approval or a specified letter that indicates likely federal approval on or before September 1, 2013. Existing law also provides that the provisions governing the various payments and grants shall remain in effect only until July 1, 2014, the date of the last payment of quality assurance fee payments, or the date of the last payment of specified payments from the department, whichever is later.

This bill would modify the calculation of the quality assurance fee and the installment payment provisions, and would make changes to the calculation of the supplemental amounts paid to private hospitals for the provision of hospital inpatient services. This bill would also increase the aggregate amount of the grants to nondesignated public hospitals for each fiscal year. This bill would reduce the amount of the proceeds from the quality assurance fee that would be transferred into the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund per subject fiscal year and would delete nondesignated public hospitals as recipients of moneys from that fund. This bill would authorize the department to make supplemental payments from that fund directly to the private hospitals, as an alternative to, and in lieu of, disbursing moneys from the fund to the LIHPs.

This bill would instead provide that the provisions governing the various payments and grants shall become inoperative on December 1, 2013, if the department has not received federal approval or the specified letter indicating likely federal approval. This bill would extend the operative date of the provisions governing the various payments and grants to January 1, 2015, and make related changes. This bill would make other technical, nonsubstantive changes to these provisions.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 14166.125 is added to the Welfare and Institutions Code, to read:

14166.125. (a) Effective the first fiscal year in which reimbursement to private hospitals is provided under the diagnosis-related group methodology established pursuant to Section 14105.28, the director shall allocate the Private Hospital Supplemental Fund among eligible private hospitals pursuant to a methodology developed in consultation with the statewide associations representing children's hospitals and private DSH hospitals.

(b) Subject to subdivision (a), for the 2013–14 fiscal year only as a transition, this methodology shall, to the extent possible, ensure that each eligible hospital is allocated funding at a proportionate level of payments it received for the 2011–12 fiscal year, taking into consideration applicable eligibility criteria and the amount of funding available in the Private Hospital Supplemental Fund established in Section 14166.12.

SEC. 2. Section 14169.3 of the Welfare and Institutions Code is amended to read:

14169.3. (a) Except as provided in Section 14169.19, private hospitals shall be paid supplemental amounts for the provision of hospital inpatient services for the program period as set forth in this section. The supplemental amounts shall be in addition to any other amounts payable to hospitals with respect to those services and shall not affect any other payments to hospitals. The supplemental amounts shall result in payments equal to the statewide aggregate upper payment limit for private hospitals for each subject fiscal year as it may be modified pursuant to Section 14169.19.

(b) Except as set forth in subdivisions (g) and (h), each private hospital shall be paid the following amounts as applicable for the provision of hospital inpatient services for each subject fiscal year:

(1) Nine hundred seventy-four dollars and ten cents ($974.10) multiplied by the hospital's general acute care days for supplemental payments for the 2011–12 subject fiscal year, one thousand eighty-nine dollars and ninety-two cents ($1,089.92) multiplied by the hospital's general acute care days for supplemental payments for the 2012–13 subject fiscal year, and one thousand two hundred sixty-four dollars and six cents ($1,264.06) multiplied by the hospital's general acute care days for supplemental payments for the 2013–14 subject fiscal year, divided by two.

(2) For the hospital's acute psychiatric days that were paid directly by the department and were not the financial responsibility of a mental health plan, six hundred ninety-five dollars ($695) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2011–12 subject fiscal year, seven hundred ninety dollars ($790) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2012–13 subject fiscal year, and nine hundred fifty-five dollars ($955) multiplied by the hospital's acute psychiatric days for supplemental payments for the 2013–14 subject fiscal year, divided by two.

(3) (A) For the 2011–12 and 2012–13 subject fiscal years, one thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital's Medicaid inpatient utilization rate is less than 41.6 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.

(B) For the 2013–14 subject fiscal year, one thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days, divided by two, if the hospital's Medicaid inpatient utilization rate is less than 41.6 percent and greater than 5 percent and at least 5 percent of the hospital's general acute care days are high acuity days.

(C) The amount under this paragraph shall be in addition to the amounts specified in paragraphs (1) and (2).

(4) (A) For the 2011–12 and 2012–13 subject fiscal years, one thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(B) For the 2013–14 subject fiscal year, one thousand three hundred fifty dollars ($1,350) multiplied by the number of the hospital's high acuity days, divided by two, if the hospital qualifies to receive the amount set forth in paragraph (3) and has been designated as a Level I, Level II, Adult/Ped Level I, or Adult/Ped Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(C) The amount under this paragraph shall be in addition to the amounts specified in paragraphs (1), (2), and (3).

(c) A private hospital that provided Medi-Cal subacute services during the 2009 calendar year and has a Medicaid inpatient utilization rate that is greater than 5 percent and less than 41.6 percent shall be paid a supplemental amount during each subject fiscal year equal to 40 percent of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011, except for the 2013–14 subject fiscal year during which the supplemental amount shall be equal to 20 percent of the Medi-Cal subacute payments paid by the department to the hospital during the 2009 calendar year, as reflected in the state paid claims file prepared by the department on July 14, 2011.

(d) (1) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (b) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to private hospitals under subdivision (b) for the subject fiscal year shall be reduced to reflect the amount for which federal financial participation is available.

(B) The amount payable under subdivision (b) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (b) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (b).

(2) In the event federal financial participation for a subject fiscal year is not available for all of the supplemental amounts payable to private hospitals under subdivision (c) due to the application of a federal upper payment limit or for any other reason, both of the following shall apply:

(A) The total amount payable to private hospitals under subdivision (c) for the subject fiscal year shall be reduced to reflect the amount for which federal financial participation is available.

(B) The amount payable under subdivision (c) to each private hospital for the subject fiscal year shall be equal to the amount computed under subdivision (c) multiplied by the ratio of the total amount for which federal financial participation is available to the total amount computed under subdivision (c).

(e) If the amount otherwise payable to a hospital under this section for a subject fiscal year exceeds the amount for which federal financial participation is available for that hospital, the amount due to the hospital for that subject fiscal year shall be reduced to the amount for which federal financial participation is available.

(f) The amounts set forth in this section are inclusive of federal financial participation.

(g) Payments shall not be made under this section to a new hospital.

(h) Payments shall not be made under this section to a converted hospital.

(i) (1) The department shall increase payments to mental health plans for the program period exclusively for the purpose of making payments to private hospitals. The aggregate amount of the increased payments for a subject fiscal quarter shall be the total of the individual hospital acute psychiatric supplemental payment amounts for all hospitals for which federal financial participation is available.

(2) The payments described in paragraph (1) may be made directly by the department to hospitals when federal law does not require that the payments be transmitted to hospitals via mental health plans.

SEC. 3. Section 14169.5 of the Welfare and Institutions Code is amended to read:

14169.5. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year as set forth in this section.

(b) The increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans.

(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for each subject fiscal year shall be the maximum amount for which federal financial participation is available

on an aggregate statewide basis for the applicable subject fiscal year as it may be adjusted pursuant to Section 14169.19.

(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensuring access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed health care plan shall not exceed an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements, taking into account the requirement that all of the increased capitation payments under this section shall be paid by the Medi-Cal managed health care plans to hospitals for hospital services to Medi-Cal enrollees of the plan.

(f) (1) The increased capitation payments to managed health care plans under this section shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence no later than the later of December 31, 2011, or within 90 days of the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

(2) (A) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the Hospital Quality Assurance Revenue Fund for the purpose of funding managed health care capitation payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary total funding for managed health care payments by December 31, 2013.

(B) To the extent feasible, the department shall accumulate funds under subparagraph (A) by retaining 10 percent of the total necessary funding from each of the 10 installments of the quality assurance fee received from hospitals under Article 5.229 (commencing with Section 14169.31), provided that the department may adjust the applicable dates and amounts as necessary to accumulate sufficient funding by December 31, 2013.

(g) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payment under this section.

(h) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services.

(2) The department may issue change orders to amend contracts with managed health care plans as needed to adjust monthly capitation payments in order to implement this section.

(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental increase in capitation rates pursuant to this section shall not be subject to negotiation and approval by the California Medical Assistance Commission.

(i) (1) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

(2) The determination under this subdivision for any month in the program period shall be made after accounting for all federal financial participation necessary for full implementation of Section 14182.15 for that month.

(j) It is the intent of the Legislature that payments made available to designated public hospitals under this section shall replace, to the extent feasible, increased revenues that could be available to the hospitals under Section 14168.7 in the absence of this section and assuming other federal funds to the hospitals would not be reduced as a result of the payments. If this intent cannot be effectuated under this act, it is the intent of the Legislature to enact subsequent legislation to accomplish this purpose through other means.

SEC. 4. Section 14169.7 of the Welfare and Institutions Code, as amended by Section 99 of Chapter 23 of the Statutes of 2012, is amended to read:

14169.7. (a) (1) Designated public hospitals shall be paid direct grants in support of health care expenditures, which shall not constitute Medi-Cal payments, and which shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The aggregate amount of the grants to designated public hospitals shall be fifty million dollars ($50,000,000) for the 2011–12 fiscal year, forty-three million dollars ($43,000,000) for the 2012–13 fiscal year, and twenty-one million five hundred thousand dollars ($21,500,000) for the 2013–14 fiscal year. The director shall allocate the amounts specified in this paragraph pursuant to paragraph (2).

(2) For the 2011–12 fiscal year, the director shall allocate the fifty million dollars ($50,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2012–13 fiscal year, the director shall allocate the forty-three million dollars ($43,000,000) identified in paragraph (1) among the designated public hospitals pursuant to a methodology developed in consultation with the designated public hospitals. For the 2013–14 fiscal year, the state shall retain the twenty-one million five hundred thousand dollars ($21,500,000) identified in paragraph (1) to pay for health care coverage for children in addition to the amounts identified in Section 14169.33.

(b) Nondesignated public hospitals shall be paid direct grants in support of health care expenditures, and shall be funded by the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31). The

aggregate amount of the grants to nondesignated public hospitals for each subject fiscal year shall be eighteen million six hundred thousand dollars ($18,600,000), except that for the 2013–14 subject fiscal year, the aggregate amount of the grants shall be nine million three hundred thousand dollars ($9,300,000). The director shall allocate the amounts specified in this subdivision among the nondesignated public hospitals pursuant to a methodology developed in consultation with the nondesignated public hospitals.

SEC. 5. Section 14169.7.5 of the Welfare and Institutions Code, as amended by Section 100 of Chapter 23 of the Statutes of 2012, is amended to read:

14169.7.5. (a) The Low Income Health Program MCE Out-of-Network Emergency Care Services Fund is hereby established in the State Treasury. The moneys in the fund shall, upon appropriation by the Legislature to the department, be used solely for the purposes specified in this section. Notwithstanding Section 16305.7 of the Government Code, any and all interest and dividends earned on money in the fund shall be used exclusively for the purposes of this section.

(b) The fund shall consist of the following:

(1) Funds transferred from governmental entities, at the option of the governmental entity, to the state for deposit into the fund in an aggregate amount of twenty million dollars ($20,000,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the transfer shall be ten million dollars ($10,000,000).

(2) Proceeds of the quality assurance fee set forth in Article 5.229 (commencing with Section 14169.31) that, subject to paragraph (1) of subdivision (a) of Section 14169.36, are transferred from the Hospital Quality Assurance Revenue Fund and deposited into the fund in an aggregate amount of sixty-six million four hundred thousand dollars ($66,400,000) per subject fiscal year, except that for the 2013–14 subject fiscal year, the aggregate amount of the proceeds of the quality assurance fee deposited into the fund shall be thirty-three million two hundred thousand dollars ($33,200,000).

(c) Any amounts of the quality assurance fee deposited to the fund in excess of the funds required to implement this section shall be returned to the Hospital Quality Assurance Revenue Fund.

(d) Any amounts deposited to the fund as described in paragraph (1) of subdivision (b) that are in excess of the funds required to implement this section shall be returned to the transferring entity.

(e) Consistent with the Special Terms and Conditions for the California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), moneys in the fund shall be used with respect to Low Income Health Programs (LIHPs) operating pursuant to Part 3.6 (commencing with Section 15909) as the source for the nonfederal share of expenditures for coverage for the Medicaid Coverage Expansion (MCE) population of medically necessary hospital emergency services for emergency medical conditions and required poststabilization care furnished by private hospitals that are outside the LIHP coverage network, subject to the following:

(1) Moneys in the fund shall only be used to fund the nonfederal share of supplemental payments made to private hospital out-of-network emergency care services providers by the LIHP for the MCE population in accordance with this section.

(2) Supplemental payments under this section shall supplement but shall not supplant amounts that would have been paid absent the provisions of this section.

(f) Moneys in the fund shall be allocated with respect to each subject fiscal year as follows:

(1) Within 60 days after the last day of each subject fiscal year, each LIHP shall report utilization data to the department on approved hospital emergency services for emergency medical conditions and required poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), provided to MCE enrollees by out-of-network private hospitals during that year. The reported data shall be as specified by the department, and shall include the number of emergency room encounters and the number of inpatient hospital days.

(2) The department shall, in consultation with the hospital community, determine the amount of funding for the nonfederal share of supplemental payments available for each reported emergency room encounter or inpatient day by dividing the total funds available by the total number of inpatient days or emergency visits in accordance with subparagraphs (A) and (B).

(A) Seventy percent of the moneys in the fund shall be allocated for the nonfederal share of supplemental payments to private hospitals for approved out-of-network inpatient hospital emergency and poststabilization care, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9).

(B) Thirty percent of the available funds shall be allocated for the nonfederal share of supplemental payments to private hospitals for approved out-of-network hospital emergency room services (excluding emergency room visits, in accordance with Paragraph 63.f.ii of the Special Terms and Conditions of California's Bridge to Reform Section 1115(a) Medicaid Demonstration (11-W-00193/9), that resulted in an approved out-of-network inpatient hospital stay), provided that for any emergency room visit that results in a hospital stay for which a supplemental payment is available under subparagraph (A), no supplemental payment shall be available under this subparagraph.

(C) The allocations and total available fund amount shall be adjusted as necessary so as to be consistent with the requirement in paragraph (1) of subdivision (g).

(g) (1) The department shall obtain federal financial participation for moneys in the fund to the full extent permitted by federal law. Moneys shall be allocated from the fund by the department to be matched by federal funds in accordance with the Special Terms and Conditions for the Medicaid

Demonstration, or pursuant to other federal approvals or waivers as necessary.

(2) The department shall disburse moneys from the fund to the LIHPs in accordance with the calculations in subdivision (f) within 60 days after completing the calculations. The moneys shall be distributed to the LIHPs solely for purposes of funding the nonfederal portion of the supplemental out-of-network amounts determined for each service in subdivision (f) to out-of-network hospital emergency care services providers.

(3) The LIHPs shall make the supplemental payments described in paragraph (2) within 30 days of receiving the nonfederal share from the department.

(h) It is the intent of the Legislature that for each subject fiscal year, the first twenty million dollars ($20,000,000), or, for subject fiscal year 2013–14, the first ten million dollars ($10,000,000), of the nonfederal share for the emergency hospital services payments are funded with intergovernmental transfers described in paragraph (1) of subdivision (b).

(i) This section shall be implemented only if, and to the extent that, both of the following conditions exist:

(1) All necessary federal approvals have been obtained for the implementation of this section and federal financial participation is available.

(2) The ability of the department to maximize federal funding is not jeopardized.

(j) In designing and implementing the program for supplemental payments created under this section, the director shall have discretion, after consultation with the hospital community and the LIHPs, to modify timelines and to make modifications to the operational requirements of this section, but only to the extent necessary to secure federal approval or to ensure successful operation of the program and to effectuate the intent of this section.

(k) Notwithstanding any other provision of this article or Article 5.229 (commencing with Section 14169.31), federal disapproval of the program developed pursuant to the requirements of this section shall not affect the implementation of the remainder of this article or Article 5.229 (commencing with Section 14169.31).

(*l*) As an alternative to, and in lieu of, disbursing moneys from the fund to the LIHPs under this section, the department may make supplemental payments from the fund directly to hospitals as determined in accordance with subdivision (f) when federal financial participation is available for those payments.

SEC. 6. Section 14169.11 of the Welfare and Institutions Code is amended to read:

14169.11. The department shall make disbursements from the Hospital Quality Assurance Revenue Fund consistent with the following:

(a) Fund disbursements shall be made periodically within 15 days of each date on which quality assurance fees are due from hospitals.

(b) The funds shall be disbursed in accordance with the order of priority set forth in subdivision (b) of Section 14169.33, except that funds may be

set aside for increased capitation payments to managed care health plans pursuant to subdivision (f) of Section 14169.5.

(c) The funds shall be disbursed in each payment cycle in accordance with the order of priority set forth in subdivision (b) of Section 14169.33 as modified by subdivision (b), and so that the supplemental payments and grants to hospitals, increased capitation payments to managed health care plans, increased payments to mental health plans, direct payments to hospitals of acute psychiatric supplemental payments, and supplemental payments for out-of-network emergency and poststabilization services for the Low Income Health Program are made to the maximum extent for which funds are available.

(d) To the maximum extent possible, consistent with the availability of funds in the quality assurance fund and the timing of federal approvals, the supplemental payments and grants to hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans under this article shall be made before December 31, 2013, except that supplemental payments for out-of-network emergency and poststabilization services for the Low Income Health Program shall be made before April 1, 2014.

(e) The aggregate amount of funds to be disbursed to private hospitals shall be determined under Sections 14169.2 and 14169.3. The aggregate amount of funds to be disbursed to managed health care plans shall be determined under Section 14169.5. The aggregate amount of direct grants to designated and nondesignated public hospitals shall be determined under Section 14169.7. The aggregate amount of supplemental payments to be disbursed to private hospitals for out-of-network and poststabilization services for the Low Income Health Program shall be determined under Section 14169.7.5.

SEC. 7. Section 14169.16 of the Welfare and Institutions Code is amended to read:

14169.16. (a) This article shall remain operative only until the later of the following:

(1) January 1, 2015.

(2) The date of the last payment of the quality assurance fee payments pursuant to Article 5.229 (commencing Section 14169.31).

(3) The date of the last payment from the department pursuant to this article.

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, unless a later enacted statute enacted before that date, deletes or extends that date.

(c) If this article becomes inoperative under paragraph (2) or (3) of subdivision (a), this article shall be repealed on January 1 of the year following the date this article becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

SEC. 8. Section 14169.17 of the Welfare and Institutions Code is amended to read:

14169.17. Notwithstanding any other provision of law, if federal approval or a letter that indicates likely federal approval in accordance with Section 14169.34 has not been received on or before December 1, 2013, then this article shall become inoperative, and as of December 1, 2013, is repealed, unless a later enacted statute, that is enacted before December 1, 2013, deletes or extends that date.

SEC. 9. Section 14169.18 of the Welfare and Institutions Code is amended to read:

14169.18. If the director determines that this article has become inoperative pursuant to Section 14169.13, 14169.16, 14169.17, or 14169.40, the director shall execute a declaration stating that this determination has been made and stating the basis for this determination. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. In addition, the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

SEC. 10. Section 14169.31 of the Welfare and Institutions Code, as amended by Section 102 of Chapter 23 of the Statutes of 2012, is amended to read:

14169.31. For the purposes of this article, the following definitions shall apply:

(a) (1) "Aggregate quality assurance fee" means, with respect to a hospital that is not a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(2) "Aggregate quality assurance fee" means, with respect to a hospital that is a prepaid health plan hospital, the sum of all of the following:

(A) The annual fee-for-service days for an individual hospital multiplied by the fee-for-service per diem quality assurance fee rate.

(B) The annual managed care days for an individual hospital multiplied by the prepaid health plan hospital managed care per diem quality assurance fee rate.

(C) The annual Medi-Cal managed care days for an individual hospital multiplied by the prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate.

(D) The annual Medi-Cal fee-for-service days for an individual hospital multiplied by the Medi-Cal per diem quality assurance fee rate.

(3) "Aggregate quality assurance fee after the application of the fee percentage" means the aggregate quality assurance fee multiplied by the fee percentage for each subject fiscal year.

(b) "Annual fee-for-service days" means the number of fee-for-service days of each hospital subject to the quality assurance fee, as reported on the days data source.

(c) "Annual managed care days" means the number of managed care days of each hospital subject to the quality assurance fee, as reported on the days data source.

(d) "Annual Medi-Cal days" means the number of Medi-Cal days of each hospital subject to the quality assurance fee, as reported on the days data source.

(e) "Converted hospital" shall mean a hospital described in subdivision (b) of Section 14169.1.

(f) "Days data source" means the hospital's Annual Financial Disclosure Report filed with the Office of Statewide Health Planning and Development as of May 5, 2011, for its fiscal year ending during 2009.

(g) "Designated public hospital" shall have the meaning given in subdivision (d) of Section 14166.1 as of January 1, 2011.

(h) "Exempt facility" means any of the following:

(1) A public hospital, which shall include either of the following:

(A) A hospital, as defined in paragraph (25) of subdivision (a) of Section 14105.98.

(B) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(2) With the exception of a hospital that is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, a hospital that is a hospital designated as a specialty hospital in the hospital's Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital's fiscal year ending in the 2009 calendar year.

(3) A hospital that satisfies the Medicare criteria to be a long-term care hospital.

(4) A small and rural hospital as specified in Section 124840 of the Health and Safety Code designated as that in the hospital's Office of Statewide Health Planning and Development Hospital Annual Financial Disclosure Report for the hospital's fiscal year ending in the 2009 calendar year.

(i) "Federal approval" means the approval by the federal government of both the quality assurance fee established pursuant to this article and the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3.

(j) (1) "Fee-for-service per diem quality assurance fee rate" means a fixed daily fee on fee-for-service days.

(2) The fee-for-service per diem quality assurance fee rate shall be three hundred eight dollars and thirty-six cents ($308.36) per day.

(3) Upon federal approval or conditional federal approval described in Section 14169.34, the director shall determine the fee-for-service per diem

quality assurance fee rate based on the funds required to make the payments specified in Article 5.228 (commencing with Section 14169.1), in consultation with the hospital community.

(k) "Fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medicare traditional," "county indigent programs-traditional," "other third parties-traditional," "other indigent," and "other payers," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(*l*) "Fee percentage" means a fraction, expressed as a percentage, the numerator of which is the amount of payments for each subject fiscal year under Sections 14169.2, 14169.3, 14169.5, and 14169.7.5, for which federal financial participation is available and the denominator of which is four billion eight hundred sixty-six million seven hundred four thousand one hundred fifteen dollars ($4,866,704,115).

(m) "General acute care hospital" means any hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(n) "Hospital community" means any hospital industry organization or system that represents hospitals.

(o) "Managed care days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medicare managed care," "county indigent programs-managed care," and "other third parties-managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(p) "Managed care per diem quality assurance fee rate" means a fixed fee on managed care days of eighty-six dollars and forty cents ($86.40) per day.

(q) "Medi-Cal days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" and "Medi-Cal managed care," for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(r) "Medi-Cal fee-for-service days" means inpatient hospital days where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal traditional" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(s) "Medi-Cal managed care days" means inpatient hospital days as reported on the days data source where the service type is reported as "acute care," "psychiatric care," and "rehabilitation care," and the payer category is reported as "Medi-Cal managed care" for purposes of the Annual Financial Disclosure Report submitted by hospitals to the Office of Statewide Health Planning and Development.

(t) "Medi-Cal per diem quality assurance fee rate" means a fixed fee on Medi-Cal days of three hundred eighty-three dollars and twenty cents ($383.20) per day.

(u) "New hospital" means a hospital operation, business, or facility functioning under current or prior ownership as a private hospital that does not have a days data source or a hospital that has a days data source in whole, or in part, from a previous operator where there is an outstanding monetary liability owed to the state in connection with the Medi-Cal program and the new operator did not assume liability for the outstanding monetary obligation.

(v) "Nondesignated public hospital" means either of the following:

(1) A public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, and satisfies the definition in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(2) A tax-exempt nonprofit hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009, is operating a hospital owned by a local health care district, and is affiliated with the health care district hospital owner by means of the district's status as the nonprofit corporation's sole corporate member.

(w) "Prepaid health plan hospital" means a hospital owned by a nonprofit public benefit corporation that shares a common board of directors with a nonprofit health care service plan.

(x) "Prepaid health plan hospital managed care per diem quality assurance fee rate" means a fixed fee on non-Medi-Cal managed care days for prepaid health plan hospitals of forty-eight dollars and thirty-eight cents ($48.38) per day.

(y) "Prepaid health plan hospital Medi-Cal managed care per diem quality assurance fee rate" means a fixed fee on Medi-Cal managed care days for prepaid health plan hospitals of two hundred fourteen dollars and fifty-nine cents ($214.59) per day.

(z) "Prior fiscal year data" means any data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or may be calculated from the most recent audited data using appropriate update factors. The data may be from prior fiscal years, current fiscal years, or projections of future fiscal years.

(aa) "Private hospital" means a hospital that meets all of the following conditions:

(1) Is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code.

(2) Is in the Charitable Research Hospital peer group, as set forth in the 1991 Hospital Peer Grouping Report published by the department, or is not designated as a specialty hospital in the hospital's Office of Statewide Health

Planning and Development Annual Financial Disclosure Report for the hospital's latest fiscal year ending in 2009.

(3) Does not satisfy the Medicare criteria to be classified as a long-term care hospital.

(4) Is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(ab) "Program period" means the period from July 1, 2011, to December 31, 2013, inclusive.

(ac) "Subject fiscal quarter" means a state fiscal quarter during the program period.

(ad) "Subject fiscal year" means a state fiscal year that ends after July 1, 2011, and begins before January 1, 2014.

(ae) "Upper payment limit" means a federal upper payment limit on the amount of the Medicaid payment for which federal financial participation is available for a class of service and a class of health care providers, as specified in Part 447 of Title 42 of the Code of Federal Regulations. The applicable upper payment limit shall be separately calculated for inpatient and outpatient hospital services.

SEC. 11. Section 14169.32 of the Welfare and Institutions Code is amended to read:

14169.32. (a) There shall be imposed on each general acute care hospital that is not an exempt facility a quality assurance fee, provided that a quality assurance fee under this article shall not be imposed on a converted hospital.

(b) The quality assurance fee shall be computed starting on July 1, 2011, and continue through and including December 31, 2013.

(c) Subject to Section 14169.34, upon receipt of federal approval, the following shall become operative:

(1) Within 10 business days following receipt of the notice of federal approval from the federal government, the department shall send notice to each hospital subject to the quality assurance fee, and publish on its Internet Web site, the following information:

(A) The date that the state received notice of federal approval.

(B) The fee percentage for each subject fiscal year.

(2) The notice to each hospital subject to the quality assurance fee shall also state the following:

(A) The aggregate quality assurance fee after the application of the fee percentage for each subject fiscal year.

(B) The aggregate quality assurance fee.

(C) The amount of each payment due from the hospital with respect to the aggregate quality assurance fee.

(D) The date on which each payment is due.

(3) The hospitals shall pay the aggregate quality assurance fee after application of the fee percentage for all subject fiscal years in 10 installments. The department shall establish the date that each installment is due, provided that the first installment shall be due no earlier than 20 days following the department sending the notice pursuant to paragraph (1), and the installments

shall be paid at least one month apart, but if possible, the installments shall be paid on a quarterly basis.

(4) Notwithstanding any other provision of this section, the amount of each hospital's aggregate quality assurance fee after the application of the fee percentage for each subject fiscal year that has not been paid by the hospital before December 15, 2013, pursuant to paragraphs (3) and (8), shall be paid by the hospital no later than December 15, 2013.

(5) (A) Notwithstanding subdivision (*l*) of Section 14169.31, for the purpose of determining the installments under paragraph (3), the department shall use an interim fee percentage as follows:

(i) One hundred percent for subject fiscal year 2011–12 until the federal government has approved or disapproved additional capitation payments described in Section 14169.5 for that subject fiscal year.

(ii) One hundred percent for subject fiscal year 2012–13 until the federal government has approved or disapproved additional capitation payments described in Section 14169.5 for that subject fiscal year.

(iii) Fifty percent for subject fiscal year 2013–14 until the federal government has approved or disapproved additional capitation payments described in Section 14169.5 for that subject fiscal year.

(B) The director may use a lower interim fee percentage for each subject fiscal year under this paragraph as the director, in his or her discretion, determines is reasonable in order to generate sufficient but not excessive installment payments to make the payments described in subdivision (b) of Section 14169.33.

(6) The director shall determine the final fee percentage for each subject fiscal year within 15 days of the approval or disapproval, in whole or in part, by the federal government of all changes to the capitation rates of managed health care plans requested by the department to implement Section 14169.5 for that subject fiscal year, but in no event later than December 1, 2013. At the time the director determines the final fee percentage for a subject fiscal year, the director shall also determine the amount of future installment payments of the quality assurance fee for each hospital subject to the fee, if any are due. The amount of each future installment payment shall be established by the director with the objective that the total of the installment payments of the quality assurance fee due from a hospital shall equal the director's estimate for each subject fiscal year for the hospital of the aggregate quality assurance fee after the application of the fee percentage.

(7) The director, within 15 days of determining the final fee percentage for a subject fiscal year pursuant to paragraph (6), shall send notice to each hospital subject to the quality assurance fee of the following information:

(A) The final fee percentage for each subject fiscal year for which the final fee percentage has been determined.

(B) The fee percentage determined under paragraph (5) for each subject fiscal year for which the final fee percentage has not been determined.

(C) The aggregate quality assurance fee after application of the fee percentage for each subject fiscal year.

(D) The director's estimate of total quality assurance fee payments due from the hospital under this article whether or not paid. This amount shall be the sum of the aggregate quality assurance fee after application of the fee percentage for each subject fiscal year using the fee percentages contained in the notice.

(E) The total quality assurance fee payments that the hospital has made under this article.

(F) The amount, if any, by which the total quality assurance fee payments due from the hospital under this article as described in subparagraph (C) exceed the total quality assurance fee payments that the hospital has made under this article.

(G) The amount of each remaining installment of the quality assurance fee, if any, due from the hospital and the date each installment is due. This amount shall be the amount described in subparagraph (E) divided by the number of installment payments remaining.

(8) Each hospital that is sent a notice under paragraph (7) shall pay the additional installments of the quality assurance fee that are due, if any, in the amounts and at the times set forth in the notice unless superseded by a subsequent notice from the department.

(9) The department shall refund to a hospital paying the quality assurance fee the amount, if any, by which the total quality assurance fee payments that the hospital has made under this article for all subject fiscal years exceed the total quality assurance fee payments due from the hospital under this article within 30 days of the date on which the notice is sent to the hospital under paragraph (7).

(d) The quality assurance fee, as paid pursuant to this section, shall be paid by each hospital subject to the fee to the department for deposit in the Hospital Quality Assurance Revenue Fund. Deposits may be accepted at any time and will be credited toward the program period.

(e) This section shall become inoperative if the federal Centers for Medicare and Medicaid Services denies approval for, or does not approve before July 1, 2014, the implementation of the quality assurance fee pursuant to this article or the supplemental payments to private hospitals described in Sections 14169.2 and 14169.3, and either or both provisions cannot be modified by the department pursuant to subdivision (d) of Section 14169.33 in order to meet the requirements of federal law or to obtain federal approval.

(f) In no case shall the aggregate fees collected in a federal fiscal year pursuant to this section, Section 14167.32, and Section 14168.32 exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(g) (1) Interest shall be assessed on quality assurance fees not paid on the date due at the greater of 10 percent per annum or the rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the

date the payment was due and shall be deposited in the Hospital Quality Assurance Revenue Fund.

(2) In the event that any fee payment is more than 60 days overdue, a penalty equal to the interest charge described in paragraph (1) shall be assessed and due for each month for which the payment is not received after 60 days.

(h) When a hospital fails to pay all or part of the quality assurance fee on or before the date that payment is due, the department may immediately begin to deduct the unpaid assessment and interest from any Medi-Cal payments owed to the hospital, or, in accordance with Section 12419.5 of the Government Code, from any other state payments owed to the hospital until the full amount is recovered. All amounts, except penalties, deducted by the department under this subdivision shall be deposited in the Hospital Quality Assurance Revenue Fund. The remedy provided to the department by this section is in addition to other remedies available under law.

(i) The payment of the quality assurance fee shall not be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(j) The department shall work in consultation with the hospital community to implement this article and Article 5.228 (commencing with Section 14169.1).

(k) This subdivision creates a contractually enforceable promise on behalf of the state to use the proceeds of the quality assurance fee, including any federal matching funds, solely and exclusively for the purposes set forth in this article as they existed on the effective date of this article, to limit the amount of the proceeds of the quality assurance fee to be used to pay for the health care coverage of children to the amounts specified in this article, to limit any payments for the department's costs of administration to the amounts set forth in this article on the effective date of this article, to maintain and continue prior reimbursement levels as set forth in Section 14169.12 on the effective date of that article, and to otherwise comply with all its obligations set forth in Article 5.228 (commencing with Section 14169.1) and this article provided that amendments that arise from, or have as a basis, a decision, advice, or determination by the federal Centers for Medicare and Medicaid Services relating to federal approval of the quality assurance fee or the payments set forth in this article or Article 5.228 (commencing with Section 14169.1) shall control for the purposes of this subdivision.

(*l*) (1) Effective January 1, 2014, the rates payable to hospitals and managed health care plans under Medi-Cal shall be the rates then payable without the supplemental and increased capitation payments set forth in Article 5.228 (commencing with Section 14169.1).

(2) The supplemental payments and other payments under Article 5.228 (commencing with Section 14169.1) shall be regarded as quality assurance payments, the implementation or suspension of which does not affect a determination of the adequacy of any rates under federal law.

(m) (1) Subject to paragraph (2), the director may waive any or all interest and penalties assessed under this article in the event that the director

determines, in his or her sole discretion, that the hospital has demonstrated that imposition of the full quality assurance fee on the timelines applicable under this article has a high likelihood of creating a financial hardship for the hospital or a significant danger of reducing the provision of needed health care services.

(2) Waiver of some or all of the interest or penalties under this subdivision shall be conditioned on the hospital's agreement to make fee payments, or to have the payments withheld from payments otherwise due from the Medi-Cal program to the hospital, on a schedule developed by the department that takes into account the financial situation of the hospital and the potential impact on services.

(3) A decision by the director under this subdivision shall not be subject to judicial review.

(4) If fee payments are remitted to the department after the date determined by the department to be the final date for calculating the final supplemental payments under this article and Article 5.228 (commencing with Section 14169.1), the fee payments shall be retained in the fund for purposes of funding supplemental payments supported by a hospital quality assurance fee program implemented under subsequent legislation, provided, however, that if supplemental payments are not implemented under subsequent legislation, then those fee payments shall be deposited in the Distressed Hospital Fund.

(5) If during the implementation of this article, fee payments that were due under Article 5.21 (commencing with Section 14167.1) and Article 5.22 (commencing with Section 14167.31), or Article 5.226 (commencing with Section 14168.1) and Article 5.227 (commencing with Section 14168.31), are remitted to the department under a payment plan or for any other reason, and the final date for calculating the final supplemental payments under those articles has passed, then those fee payments shall be deposited in the fund to support the uses established by this article.

SEC. 12. Section 14169.33 of the Welfare and Institutions Code, as amended by Section 104 of Chapter 23 of the Statutes of 2012, is amended to read:

14169.33. (a) (1) All fees required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department.

(2) The department shall directly transmit the fee payments to the Treasurer to be deposited in the Hospital Quality Assurance Revenue Fund, created pursuant to Section 14167.35. Notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on deposits in the fund from the proceeds of the fee assessed pursuant to this article shall be retained in the fund for purposes specified in subdivision (b).

(b) Notwithstanding subdivision (c) of Section 14167.35 and subdivision (b) of Section 14168.33, all funds from the proceeds of the fee assessed pursuant to this article in the Hospital Quality Assurance Revenue Fund, together with any interest and dividends earned on money in the fund, shall, upon appropriation by the Legislature, continue to be used exclusively to enhance federal financial participation for hospital services under the

Medi-Cal program, to provide additional reimbursement to, and to support quality improvement efforts of, hospitals, and to minimize uncompensated care provided by hospitals to uninsured patients, as well as to pay for the state's administrative costs and to provide funding for children's health coverage, in the following order of priority:

(1) To pay for the department's staffing and administrative costs directly attributable to implementing Article 5.228 (commencing with Section 14169.1) and this article, not to exceed two million five hundred thousand dollars ($2,500,000) for the program period.

(2) To pay for the health care coverage for children in the amount of eighty-five million dollars ($85,000,000) for each subject fiscal quarter during the 2011–12 subject fiscal year, in the amount of one hundred thirty-four million two hundred fifty thousand dollars ($134,250,000) for each subject fiscal quarter during the 2012–13 subject fiscal year, and in the amount of one hundred forty-four million two hundred fifty thousand dollars ($144,250,000) for each subject fiscal quarter during the 2013–14 subject fiscal year.

(3) To make increased capitation payments to managed health care plans pursuant to Article 5.228 (commencing with Section 14169.1).

(4) To reimburse the General Fund for the increase in the overall compensation to a private hospital that is attributable to its change in status from contract hospital to noncontract hospital, pursuant to subdivision (a) of Section 14169.10.

(5) To make increased payments or grants to hospitals pursuant to Article 5.228 (commencing with Section 14169.1).

(6) To make increased payments to mental health plans pursuant to Article 5.228 (commencing with Section 14169.1).

(7) To make supplemental payments for out-of-network emergency and poststabilization services provided by private hospitals to Medicaid Coverage Expansion enrollees in the Low Income Health Program in the amount of thirty-three million two hundred thousand dollars ($33,200,000) for each fiscal quarter pursuant to Section 14169.7.5.

(c) Any amounts of the quality assurance fee collected in excess of the funds required to implement subdivision (b), including any funds recovered under subdivision (d) of Section 14169.13 or subdivision (e) of Section 14169.38, shall be refunded to general acute care hospitals, pro rata with the amount of quality assurance fee paid by the hospital, subject to the limitations of federal law. If federal rules prohibit the refund described in this subdivision, the excess funds shall be deposited in the Distressed Hospital Fund to be used for the purposes described in Section 14166.23, and shall be supplemental to and not supplant existing funds.

(d) Any methodology or other provision specified in Article 5.228 (commencing with Section 14169.1) or this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance the probability that federal approval can be obtained, provided the modifications do not violate the spirit and intent of

Article 5.228 (commencing with Section 14169.1) or this article and are not inconsistent with the conditions of implementation set forth in Section 14169.40.

(e) The department, in consultation with the hospital community, shall make adjustments, as necessary, to the amounts calculated pursuant to Section 14169.32 in order to ensure compliance with the federal requirements set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this article or Article 5.228 (commencing with Section 14169.1) by means of provider bulletins, all plan letters, or other similar instruction, without taking regulatory action. The department shall also provide notification to the Joint Legislative Budget Committee and to the appropriate policy and fiscal committees of the Legislature within five working days when the above-described action is taken in order to inform the Legislature that the action is being implemented.

SEC. 13. Section 14169.41 of the Welfare and Institutions Code is amended to read:

14169.41. (a) This article shall remain operative only until the later of the following:

(1) January 1, 2015.

(2) The date of the last payment of the quality assurance fee payments pursuant to this article.

(3) The date of the last payment from the department pursuant to Article 5.228 (commencing with Section 14169.1).

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, unless a later enacted statute enacted before that date, deletes or extends that date.

(c) If this article becomes inoperative under paragraph (2) or (3) of subdivision (a), this article shall be repealed on January 1 of the year following the date this article becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

SEC. 14. Section 14169.42 of the Welfare and Institutions Code is amended to read:

14169.42. If the director determines that this article has become inoperative pursuant to Section 14169.37, 14169.38, 14169.40, or 14169.41, the director shall execute a declaration stating that this determination has

been made and stating the basis for this determination. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the Legislature. In addition, the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

SEC. 15. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to increase Medi-Cal payments to hospitals and improve access to care at the earliest possible time, it is necessary that this act take effect immediately.

O